PRINTED: 02/22/2011 FORM APPROVED

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		NVN168AGC		B. WING		01/2	5/2011	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE			
			975 CORDO RENO, NV					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ACTION SHOULD BE COMPLET TO THE APPROPRIATE DATE		
Y 000	Initial Comments			Y 000				
	The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 1/25/11. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for nine Residential Facility for Group beds for elderly and disabled persons, Category II residents. The census at the time of the survey was seven. Seven resident files were reviewed and two employee files were reviewed. One discharged resident file was reviewed.							
	The following deficier	ncies were identified:						
Y 430 SS=E	449.229(1) Protection	n from Fire		Y 430				
	ensure that the facility regulations adopted be pursuant to chapter 4 ordinances relating to	of a residential facility s y complies with the by the State Fire Marsha 77 of NRS and all local o safety from fire. The eved for residency by the	al					

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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NVN168AGC			B. WING		01/25/2011				
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	ATE, ZIP CODE		<u></u>		
FAMILY HOME CARE RHL				975 CORDONE AVE RENO, NV 89502					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATIO			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE		
Y 430	Continued From page 1 This Regulation is not met as evidenced by: Based on observation and testing on 1/25/11, the			Y 430					
	facility failed to mainta emergency lights for a the facility (in the livin Severity: 2 Scope	in							
Y 859 SS=D	NAC 449.274 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by his physician. The resident must be cared for pursuant to any instructions provided by the resident's physician.		а	Y 859					
			f a by						
	Based on record revieus failed to ensure that 1	ot met as evidenced by: ew on 1/25/11, the facil I of 7 residents received prior to admission (Res	ity d a						
	This was a repeat def State Licensure surve	ficiency from the 8/25/0 ey.	9						
	Severity: 2 Scope: 1								

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		NVN168AGC				01	125/2011	
NAME OF PROVIDER OR SUPPLIER FAMILY HOME CARE RHL			975 CORDONE AVE RENO, NV 89502					
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY O	JLL	ID PREFIX TAG	ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULD BE				